STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING 01 B. WING	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure Survey and the Preoccupanciy Survey for the addition of 5 title 18 SNF beds, one each to rooms 115, 117, 119, 121 and 123 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/31/13 Facility Number: 000079 Provider Number: 155159 AIM Number: 100266160 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code and Preoccupancy survey, Summit City Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities.	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. This facility respectfully requests a revisit on or after March 2, 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	This two story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, areas open to the corridor and battery operated smoke detectors in the resident rooms. The facility has a capacity of 88 and had a census of 69 at the time of this survey. All areas where the residents have customary access are sprinklered. The facility does have a shed providing facility services that was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/06/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 second floor west wing dining rooms was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient	K0017	**K 017 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure that all areas open to the corridors are supervised by electrically supervised automatic smoke detection system. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The battery operated smoke detector will be replaced. The electrically	03/02/2013

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	practice could affect any of the 15 west wing second floor residents. Findings include: Based on an observation with the Maintenance Supervisor on 01/31/13 at 12:54 a.m., the second floor west wing dining room lacked corridor doors and was open to the corridor. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the second floor west wing dining room was not protected by an electrically supervised automatic smoke detection system. The Maintenance Supervisor confirmed the smoke detector in the second floor west wing dining room was battery operated by removing the device from the wall. 3.1-19(b)		supervised automatic smoke detection system was installed on 2-8-13. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · Ensure all areas open to the corridors are supervised by electrically supervised automatic smoke detection system. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:** · The battery operated smoke detector will be replaced. The electrically supervised automatic smoke detection system was installed on February 8, 2013. · The Maintenance Director or Designee will check all areas open to the corridors are supervised by electrically supervised	

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			automatic smoke detection system by March 2, 2013. · The Maintenance Director is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Smoke Detector Audit will be utilized monthly x 3 and quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion Date: 3/2/13**	

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure 1 of 3 second floor exit discharge paths was readily accessible at all times. This deficient practice could affect 15 residents in the west wing on the second floor. Findings include: Based on observation with the Maintenance Supervisor on 01/31/13 at 12:50 p.m., the west wing exit stairway door magnetic lock did not release when the Maintenance Supervisor entered the code that was posted near the door. The Maintenance Supervisor acknowledged the door did not release with any entry into the keypad but did release upon activation of the fire alarm system. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 3 second floor exit doors was accessible. Health care occupancies permit delayed egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable	K0038	**K 038 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure all exit discharge paths are readily accessible at all times. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The facility repaired the code box on February 8, 2013. · "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" sign, with letters 1 inch high and not less than 1/8 inch in width, was installed on the east wing egress door. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**	03/02/2013

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	sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" This deficient practice could affect 16 residents in the east wing on the second floor. Findings include: Based on observations with the Maintenance Supervisor on 01/31/13 at 1:17 p.m., the second floor east wing exit door was equipped with electromagnetic locks that released after pushing the door for 15 seconds but it lacked the proper signage. Based on an interview with the Maintenance Supervisor at the time of observation, he was not aware the exit door was set up with a delayed egress locking system. 3.1-19(b)		· All residents have the potential to be affected by the alleged deficient practice. · All exit discharge paths will be audited on or before March 2 nd 2013 to ensure readily accessibility at all times. · All egress doors will be audited to ensure proper signage on or before March 2, 2013. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · All exit discharge paths will be audited on or before March 2 nd 2013 to ensure readily accessibility at all times. · All egress doors will be audited to ensure proper signage on or before March 2, 2013. · The Maintenance Director/Designee will in-service the management team to immediately report any issues with the exit door codes obstructing the ability to open the door and/or proper signage.	

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			· The Maintenance Director is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Egress Door Audit (Code and Signage) will be utilized every month x 3 and quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. • Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 03/02/2013**	

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K0062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads in 1 of 1 Cottage spas were unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect 4 residents. Findings include: Based on observations with the Maintenance Supervisor on 01/31/13 at 2:05 p.m., three shower curtains in the Cottage spa were solid plastic from the top to bottom of the curtain. Each curtain was mounted near the ceiling obstructing the sprinkler head in the shower stall from providing coverage outside the shower stall. This was acknowledged by the Maintenance Supervisor at the time of observation.	K0062	**K 062 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The plastic solid shower curtain from top to bottom in the Cottage Spa was removed on 2-1-13. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · Residents residing on the cottage have the potential to be affected by the alleged deficient practice. · All Spa room shower stalls will be checked by maintenance staff on or before March 2, 2013 to ensure sprinkler systems are continuously maintained in reliable operating condition. **What measures will**	03/02/2013

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	3.1-19(b)		**be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · The plastic solid shower curtain from top to bottom in the Cottage Spa was removed on 2-1-13. · The Maintenance Director/Designee will in-service Department Heads on sprinkler head obstruction and monitoring on or by March 2, 2013. · The Maintenance Director is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Sprinkler Head Inspection will be utilized every month x 3 and every quarter x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 03/02/2013**	

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K0064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 1 K-Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice was not in a resident care area by could affect any number of kitchen staff. Findings include: Based on observation with the Maintenance Supervisor on 01/31/13 at	K0064	**K 064 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure K-Class portable fire extinguishers are labeled with a placard. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** ·The appropriate placard will be professionally posted by the K-Class Fire Extinguisher in the kitchen on 2-18-13. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All staff in the kitchen have the potential to be effected by the alleged deficient practice. · All fire extinguishers will	03/02/2013

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	2:32 p.m., the kitchen K-Class fire extinguisher lacked a placard. Based on an interview with the Maintenance Supervisor at the time of observation, the kitchen K-Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen fire suppression system. 3.1-19(b)		be checked by maintenance staff on or before March 2, 2013 to ensure appropriate signage. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · All fire extinguishers will be monitored on an on-going basis to ensure appropriate signage by Maintenance Director/ Designee. · The Maintenance Director/Designee will in-service management team on the appropriate signage and monitoring of fire extinguishers by March 2, 2013. · The Maintenance Director is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Fire Extinguisher Audit will be utilized monthly x 3 and	

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			quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. • Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 03/02/2013**	

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K0069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96			
	Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was maintained in proper working order. NFPA 96, 10-6.5 requires inspection and testing of the total operation and all safety interlocks in accordance with the manufacturer's instructions shall be performed by qualified service personnel a minimum of once every 6 months or more frequently if required. This deficient practice was not in a resident area but could affect kitchen staff. Findings include: Based on record review with the Maintenance Supervisor on 01/31/13 at 1:58 p.m., the 360 Degree Services kitchen hood cleaning report titled "Service Report" dated 10/08/12 stated "Cannot access ductwork from kitchen area. Access door is screwed on and painted over. Inaccessible area exist: All ductwork. Cleaned all accessible areas of exhaust systems." Based on an interview with the Maintenance Supervisor at the time of record review, he confirmed the inaccessible areas were not properly cleaned.	K0069	**K 069 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure the kitchen exhaust system is inspected and tested of the total operation and all safety interlocks in accordance with the manufacturer's instructions shall be performed by qualified service personnel a minimum of once every six months or more frequently if required. However based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** ·On February 5, 2013, 360 Services installed an access door and inspected and cleaned the kitchen exhaust system. **How will you identify other residents having the potential to be affected by the same deficient practice**	03/02/2013

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	3.1-19(b)		**and what corrective action will be taken:** · All kitchen staff have the potential to be effected by the alleged deficient practice. · Executive Director in-serviced the Maintenance Department on how to ensure there is not a blockage in the kitchen exhaust system that will interfere with cleaning. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** ·The kitchen exhaust system will be monitored on an on-going basis to ensure cleaning and inspections are happening every 6 months per contact with 360 Services. ·Maintenance Director is responsible for program compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · The kitchen exhaust	

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	155159	A. BUILDING 01 B. WING	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805

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			system will be monitored on an on-going basis to ensure cleaning and inspections are happening every 6 months by the preventative maintenance book per contact with 360 Services. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 03/02/2013**	

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice could affect residents in the second floor dining room which has a seating capacity of 28 residents. Findings include: Based on observation with the Maintenance Supervisor on 01/31/13 at 12:45 p.m., the mechanical ventilation in the second floor oxygen	K0143	**K 143 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure oxygen is in an area that is mechanically ventilated. However, based on the alleged deficient practice the following was implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The switch in the oxygen room was removed and the exhaust fan was rewired to provide continuous	03/02/2013

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	transfilling/storage room which contained at least four large stationary containers of liquid oxygen was controlled by an electrical wall switch. The oxygen storage room located near the second floor dining room was identified with a sign as a transfilling area. At the time of observation, the Maintenance Supervisor turned the wall switch to the off position confirming the switch did control the mechanical ventilation for the oxygen storage room. 3.1-19(b)		ventilation on 2-1-13. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · All oxygen rooms will be checked by the Maintenance Department on or before March 2, 2013 to ensure mechanical ventilation. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · All oxygen rooms will be monitored on an on-going basis to ensure continuous mechanical ventilation. · The Maintenance Director/Designee will in-service all managers that the exhaust fan was rewired to provide continuous ventilation March 2, 2013. · The Maintenance Director is in charge of program compliance.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: · A CQI monitoring tool called Oxygen Room Audit will be utilized monthly x 3 and quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI Committee. If threshold of 100% is not met, an action plan will be developed. · Non-compliance with facility procedure may result in disciplinary action up to and including termination. **Compliance date: 03/02/2013**	

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K0147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring to provide power for medical equipment. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 1 of 16 east hall second floor residents. Findings include: Based on observation with the Maintenance Supervisor on 01/31/13 at 1:12 p.m., an oxygen concentrator was supplied with electricity by extension cord power strips in resident room 217 on the second floor. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)	K0147	**K 147 NFPA 101** **Miscellaneous** It is the practice of this facility to ensure flexible cords are not used as a substitute for fixed wiring. However, based on the alleged deficient practice the following was implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The extension cord power strips in room 217 was removed from the building on1-31-13. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · All rooms will be checked on or before March 2,	03/02/2013

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			2013 to ensure no flexible cords are being used as a substitute for fixed wiring to operation medical equipment. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · All rooms will be monitored on an on-going basis to ensure no flexible cords are being used as a substitute for fixed wiring by the Maintenance Director. · The Maintenance Director/Designee will in-service all managers on the prohibited use of flexible cords being used as a substitute for fixed wiring by March 2, 2013. · The Maintenance Director is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Flexible Wiring will be utilized weekly x 4, monthly x	

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			3 and quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI Committee. If threshold of 100% is not met, an action plan will be developed. · Non-compliance with facility procedure may result in disciplinary action up to and including termination. **Compliance date: 03/02/2013**	